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**MEDICAL CERTIFICATION**

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5M 2/57



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9097

09088

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Johnsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETTA MAY BARTON</u>				4. DATE OF DEATH Month Day Year <u>Aug. 19 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John M. Quiterman</u>				14. MOTHER'S MARDEN NAME <u>Rebecca A. Etzler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT Address <u>Mr. Russell M. Barton, Union Bridge, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.0</u> DUE TO <u>acute coronary attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO <u>3 yrs</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Recto-sigmoid</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 14, 1961</u> to <u>Aug. 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 19, 1961</u> , and that death occurred at <u>1:45 P.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Culler</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>JOHN M. CULLER</u>	
22d. ADDRESS <u>15 E SECOND ST, FREDERICK, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Y. C. Barton, Walkersville, Md.</u>				25a. REC'D BY REGISTRAR <u>Aug 22 61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hump</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-22

CERTIFICATE OF DEATH

1902

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M

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9098

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09089

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN 1b <b>13 days</b>				d. STREET ADDRESS <b>Rosemont Ave., ext.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>John</b>		Middle <b>H.</b>		Last <b>Boller</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/22/86</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Issac Boller</b>				14. MOTHER'S MAIDEN NAME <b>Susan Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <b>216-16-0487A</b>		17. INFORMANT <b>Robert A. Schell, Montevue, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <b>arteriosclerotic gangrene rt foot</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/25</b> 19 <b>61</b> to <b>8/7</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/7</b> 19 <b>61</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank Damaz</b>				22b. DATE SIGNED <b>8/8/61</b>		22c. PHYSICIAN'S NAME (Type) <b>DAMAZO, Frank</b>	
22d. ADDRESS <b>7 W 3rd St Frederick</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Thermont Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. C. Barton</b>				25a. REC'D BY REGISTRAR <b>WALKERSVILLE, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

8038

*[Faint, mostly illegible handwritten text on a death certificate form. The form includes fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and Place of Death. The handwriting is cursive and difficult to decipher.]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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V5. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9099 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09090									
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#4				
c. LENGTH OF STAY in 1b Since 8/21/61					d. STREET ADDRESS Feagaville				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FANNIE S. BURKETT					4. DATE OF DEATH August 25, 1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 6 Sept 1872				
9. AGE (In years last birthday) 88					10. IF UNDER 1 YEAR Months Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work					10b. KIND OF BUSINESS OR INDUSTRY At Home				
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Frederick Cline					14. MOTHER'S MAIDEN NAME Melissa Webster				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None				
17. INFORMANT Mrs. Pearl E. Fisher (Same as item #2)					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Laceration of Scalp Injury to Skull & Brain DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps at home 20c. TIME OF INJURY Month, Day, Year 8-21-61 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Feagaville-Frederick-Maryland (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-26-61 ACTUAL SIGNATURE B. O. Thomas EXAMINER'S NAME (Type) B. O. Thomas, M. D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8-28-61 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery 22d. LOCATION (City, town, or country) (State) Frederick, Maryland 23. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Maryland 24a. REC'D BY REGISTRAR AUG 29 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED



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Investigation

Investigation

Since 8/1/61

Headquarters, Memorial Hospital

at Seattle

Remarks: None

at Seattle 1-15

Home-work

at home

Investigation of

business records

None

at Seattle, 1-15 (see also 1-15)

Investigation of

investigation of health records of child in Seattle

Full name given at home

-1-1

Seattle, 1-15 (see also 1-15)

R. O. Thomas, M. D.

-1-1

Seattle, 1-15

R. O. Thomas & Son, Physicians, Seattle, Washington



## CERTIFICATE OF DEATH

Reg. Dist. No. 09091

9100

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Elizabeth</i> Last <i>Buser</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>2</i> Year <i>1961</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 25 1887</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George P. Kauffman</i>				14. MOTHER'S MAIDEN NAME <i>Susan Starnes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				17. INFORMANT Address <i>Mrs Emma Chipley Walkersville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260 X Cerebral Hemorrhage</i> DUE TO <i>Gratuitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gratuitis</i> DUE TO (c) <i>Gratuitis</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>7 mos</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>July 27, 1961</i> to <i>Aug 2, 1961</i> that I last saw the deceased alive on <i>Aug 2, 1961</i> and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.			
21. I certify that I attended the deceased from <i>July 27, 1961</i> to <i>Aug 2, 1961</i> that I last saw the deceased alive on <i>Aug 2, 1961</i> and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Miner Bridge Anzle</i>			
ACTUAL SIGNATURE <i>C. H. MESSLER</i>				DATE SIGNED <i>Aug 2, 1961</i>			
PHYSICIAN'S NAME (Type) <i>C. H. MESSLER</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/5/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Rocky Hill</i>		22d. LOCATION (City, town, or county) (State) <i>W. Woodboro, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Y.C. Barton, Walkersville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>AUG 7 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thoma</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9101  
CERTIFICATE OF DEATH

09092

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>50 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>49-A South Market Street</b>				d. STREET ADDRESS <b>49-A South Market Street</b>			
3. NAME OF DECEASED (Type or print) <b>Melvin Augustus Carbaugh</b>				4. DATE OF DEATH <b>August 20, 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-14-1889</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. C &amp; P. Telephone Co. Employee</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Adams Co., Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Adam C. Carbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Annie Wagaman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-05-0813</b>		17. INFORMANT <b>Mrs. Emma Carbaugh</b>		Address <b>Frederick, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis with cerebral vascular accident + peripheral vascular disease</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-14</b> , 19 <b>61</b> , to <b>8-20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-19</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Rex Martin</b>				M.D. <b>M.D.</b>		22b. DATE SIGNED <b>8-21-1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Rex Martin</b>				22d. ADDRESS <b>220 North Market Street Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-23-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dalley &amp; Son</b>		25a. REC'D BY REGISTRAR <b>August 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur B. ...</b>			

1010



Fredrick

Maryland

Fredrick

Fredrick

70 years

Fredrick

10-A South Market Street

10-A South Market Street

Malvin

Augustus

Carbaugh

August

20

1-21-1909

70

White

Male

Nat. C. & P. Telephone Co. Employee

Adams Co., Pennsylvania U.S.A.

Adams Co. Carbaugh

Uncle William

212-05-0815

No

Frederick, Maryland

*Handwritten note:*  
Admitted to membership in the  
Frederick Lodge No. 1010

8-19-01

8-14-01

8-20-01

*Handwritten signature:* J. H. Martin

Mr. Rex Martin

M.D.

220 North Market Street, Frederick, Md.

8-21-1901

Printed

8-21-1901

Mr. Oliver Cammery

Frederick, Maryland

Robert E. Bailey & Son

Frederick, Maryland

Frederick, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9103

## CERTIFICATE OF DEATH

Reg. Dist. No. 09093

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>New York</i> b. COUNTY <i>Westchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chappagua</i>	
c. LENGTH OF STAY IN 1b <i>5 wks.</i>		d. STREET ADDRESS <i>Highland Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Monocacy Hall Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>KATHERINE LEONARD CHAMBERLAIN</i>		4. DATE OF DEATH <i>August 1 1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 5, 1978</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert W. Leonard</i>		14. MOTHER'S MAIDEN NAME <i>Mary Barnes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs E. J. Murcek, Keysmar, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> DUE TO <i>153.2</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of descending colon</i> DUE TO (c) <i>3 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1961</i> , to <i>August 1, 1961</i> , that I last saw the deceased alive on <i>July 31</i> , 19 <i>61</i> , and that death occurred at <i>12:15 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Walkersville, Maryland</i> DATE SIGNED <i>August 26, 1961</i>			
ACTUAL SIGNATURE <i>Ernest A. Dettbarn</i> M.D.		PHYSICIAN'S NAME (Type) <i>ERNEST A. DETTBARN</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 2, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Olivet Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton</i> ADDRESS <i>Walkersville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 4 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







## 9102

09094

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKY RIDGE</b>	c. LENGTH OF STAY IN 1b <b>2 YEARS</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LIBBY</b> Middle <b>JAMESON</b> Last <b>COLSON</b>	4. DATE OF DEATH Month <b>AUG</b> Day <b>26</b> Year <b>1961</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 16 - 1876</b>
9. AGE (In years last birthday) <b>85</b> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>
11. BIRTHPLACE (State or foreign country) <b>WEST VA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JAMES M JAMESON</b>	14. MOTHER'S MAIDEN NAME <b>BARBARA BRITTON</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>NONE</b>
17. INFORMANT <b>JOHN COLSON</b>	Address <b>ROCKY RIDGE MD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>ASHTCUD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHTCUD</b> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <b>12 days ± 20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>1959</b> to <b>8-25, 1961</b> , that (1) (we) last saw the deceased alive on <b>8-24-61</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.	22a. SIGNATURE <b>Thomas A. Dove</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>8-28-61</b>
22c. PHYSICIAN'S NAME (Type) <b>THOMAS A DOVE</b>	22d. ADDRESS <b>14 West. Main St. Thurmont, Md</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>AUG 29 - 1961</b>
23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN</b>	23d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>D D Hartley &amp; Sons New Windsor</b> ADDRESS	25a. REC'D BY REGISTRAR DATE <b>AUG 30 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>

3103

CERTIFICATE OF DEATH

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(I)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9104

Item 1 Film G294 9/5/61 ink

09095

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>local hotel at dinner</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b> d. STREET ADDRESS <b>Potomac Ave.</b>		
3. NAME OF DECEASED (Type or print) <b>Joseph S. Fischer</b>			4. DATE OF DEATH <b>8 24 1961</b>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/11/1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>manager &amp; salesman retail janitorial supplies</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Henry Schulz</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Fischer</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give year or dates of service)		
16. SOCIAL SECURITY NO. <b>215-24-7676</b>			17. INFORMANT <b>Mrs. Joseph Fischer, Braddock Heights, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Hypertensive arteriosclerotic heart disease</b> DUE TO (c) <b>2 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> , 19 <b>61</b> , to <b>8/24</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/18</b> , 19 <b>61</b> , and that death occurred at <b>4/7</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>James B. Thomas</b>		M.D. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/28/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	
23d. LOCATION (City, town or county) <b>Middletown, Md.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>		ADDRESS		25a. REG. DAY REGISTRAR DATE <b>AUG 29 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>					

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Shirley M. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9105											
09096											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>						c. LENGTH OF STAY IN 1b <b>Frederick</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>610 Schley Avenue</b>						d. STREET ADDRESS <b>610 Schley Avenue</b>					
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>OLIVER</b> Last <b>FLOOK SR.</b>						4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1909</b>		9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>52</b> Days <b>19</b> Hours <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pullman Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railway</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oliver J. Flook</b>						14. MOTHER'S MAIDEN NAME <b>Florence M. Tritapoe</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-07-8237</b>		17. INFORMANT <b>Mrs. Agatha A. Flook</b>		Address <b>Same as item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> , 1961, to <b>8/2</b> , 1961, that (I) (we) last saw the deceased alive on <b>7/31</b> , 1961, and that death occurred <b>5:30 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Richard C. Reynolds,</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>August 4, 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Richard C. Reynolds M.D.</b>						22d. ADDRESS <b>9 East Church Street, Frederick, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-6-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Boonsboro Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison and Son, Frederick, Maryland</b>						25a. REC'D BY REGISTRAR <b>AUG 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Finner</b>			

3103

(M)

Frederick

Frederick

619 Solon Avenue

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SILVER

BLACK ST.

Albany

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June 19, 1909

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William Connors

Way

Frederick, Maryland

USA

William H. Johnson

117-11-1100

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112-07-1237

Rev. John A. Black

Same as above

Announcement

7/31

5:30 PM

Richard G. Reynolds M.D.

2 East Church Street, Frederick, Md.

8-5-01

Boonshoro Cemetery

Boonshoro

Frederick

M. R. Nicholson and Son, Frederick, Maryland



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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>Since 2/25/58</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Maryland Odd Fellows Home</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>FOREMAN</b>						4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1961</b>																	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 Jan 1881</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>0</b> Hours <b>0</b> Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Utility Man</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>I.O.O.F. Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Thurmont, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
13. FATHER'S NAME <b>Henry C. Foreman</b>						14. MOTHER'S MAIDEN NAME <b>Ann E. Black</b>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-12-3450</b>		17. INFORMANT Address <b>Md. Odd Fellows Home Records (Same as item #1)</b>																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiovascular disease</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma left lung</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Rem. +</b>																							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)													
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 21</b> , 19 <b>61</b> , to <b>Aug 21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug 21</b> , 19 <b>61</b> , and that death occurred <b>2:45 P</b> , from the causes and on the date stated above.																							
22a. SIGNATURE <b>B. O. Thomas</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>22 Aug 1961</b>															
22c. PHYSICIAN'S NAME (Type) <b>B. O. Thomas, M. D.</b>						22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cemetery</b>			23d. LOCATION (City, town or county) <b>Thurmont, Md.</b> (State)														
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>						25a. REC'D BY REGISTRAR <b>AUG 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>															

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William O. Jones

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August 21, 1958

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Helms-Berry, Ann

Ann A. Black

Berry, C. Brown

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State Records - Room 401  
Bill Ballou

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W. C. Thomas, Jr.

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W. C. Thomas, Jr., Thomson, Maryland

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 09098

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u>			
c. LENGTH OF STAY IN 1b <u>15 yrs.</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>May</u> Last <u>Garber</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1890</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Allen Zachariah Burrier</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Lease</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>-NO-</u>		17. INFORMANT <u>Ira Garber</u>		Address <u>New Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Uterus</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>Aug.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug. 27</u> 19 <u>61</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W.B. Culwell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug. 28, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				22d. ADDRESS <u>Mt. Airy, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Libertytown, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Barton, Walkersville, Md.</u>				25a. REC'D BY REGISTRAR <u>Aug 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hump</u>	

MEDICAL CERTIFICATION

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THE STATE OF MARYLAND  
COUNTY OF BALTIMORE  
I, the undersigned, Clerk of the Board of Health,  
do hereby certify that the within and foregoing  
is a true and correct copy of the original  
as the same appears from the records of the  
Bureau of Vital Statistics.

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9108

## CERTIFICATE OF DEATH

09099

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>619 Magnolia Avenue</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE SARAH GARDNER</b>		4. DATE OF DEATH Month Day Year <b>August 15, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 28, 1891</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Millard F. Lease, Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Fannie G. Danner</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT Address <b>Mrs. Edith L. Staley, Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>29 yrs</b> <b>7 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-14</b> , 1961, to <b>8-15</b> , 1961, that (I) (we) last saw the deceased alive on <b>8-15</b> , 1961, and that death occurred at <b>7:00A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Rex R. Martin</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin, M.D.</b>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>North Market St., Frederick, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 18, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. RECEIVED BY REGISTRAR <b>Aug 16 61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

1963



No

L. A. Robinson & Son, Frederick, Maryland  
Jan. 18, 1963  
John Oliver Gentry

*Handwritten signature or name*

2000

John Oliver Gentry, Frederick, Maryland  
L. A. Robinson & Son

*Handwritten text, possibly a signature or address*

Frederick, Maryland

January 18, 1963

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9109  
CERTIFICATE OF DEATH  
09160

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#7</b>				c. LENGTH OF STAY IN lb <b>Since 9-6-56</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Chronic Hospital</b>				d. STREET ADDRESS <b>12 East Third Street</b>			
3. NAME OF DECEASED (Type or print) <b>IDA BELLE GETZENDANNER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6 Jan 1864</b>	
9. AGE (In years last birthday) yrs. <b>97</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lewistown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Alexander Ramsburg</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Cronise</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Mattie S. Ramsburg (Same as item #2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myoscarditis</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>				INTERVAL BETWEEN ONSET AND DEATH <b>57H.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(his hospital)</del> attended the deceased from <b>Sept 3</b> 19 <b>61</b> to <b>Aug 3</b> 19 <b>61</b> ; that (I) <del>(we)</del> last saw the deceased alive on <b>Aug 3</b> 19 <b>61</b> , and that death occurred at <b>8:30P</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>H. F. Kline</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5 Aug 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. F. Kline, M. D.</b>				22d. ADDRESS <b>7 N. Market St., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-7-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>AUG 7 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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H. H. Richardson & Son, Frederick, Maryland

• 1985 •

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9110

Information from birth certif. 8/21/61 iwk

09101

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X I J A M S V I L L E</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>GRAY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1961</u>
9. AGE (In years last birthday) yrs. <u>40</u>		10. IF UNDER 1 YEAR Months <u>40</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Auburn Gray</u>		14. MOTHER'S MAIDEN NAME <u>Maude Simms</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>7610</u>	
17. INFORMANT <u>Charles E Wright</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary aneurysm</u> 7610 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>precipitous delivery</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 14</u> 19 <u>61</u> , to <u>Aug 14</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 14</u> 19 <u>61</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles E Wright</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Hospital</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. David Youngblood</u>		25a. REC'D BY REGISTRAR <u>Aug 16 '61</u>	
ADDRESS <u>Frederick, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09162

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles F. Hahn</b>		4. DATE OF DEATH <b>Aug 30 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1875</b>
9. AGE (In years lost birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13. FATHER'S NAME <b>James A. Hahn</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-3184</b>	
17. INFORMANT <b>Mrs. Silas Kline, Keymar, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Bronchopneumonia, Bilateral</b> (c) <b>as noted Pyelonephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>as noted</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign prostatic hypertrophy with urinary obstruction</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/12 1961</b> to <b>8/30 1961</b> , that (I) (we) last saw the deceased alive on <b>8/29 1961</b> , and that death occurred at <b>2:45 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry V. Chase</b>		22b. DATE SIGNED <b>8/30/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>		22d. ADDRESS <b>4 E. Church St Frederick Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Haugh's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Keymar, Carroll, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Skiles</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>	
ADDRESS <b>E.O. Fuss &amp; Son Taneytown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

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Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1911-11-11	
Place of Birth		Cause of Death		Occupation		Residence	
New York		Heart Disease		Farmer		123 Main St	
Physician		Burial Place		Interment		Remarks	
Dr. Smith		Cemetery		Buried		No autopsy	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09103

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Emma</b> Last <b>Hahn</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1908</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lyle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Luther Hahn, Route #1, Emmitsburg, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Marked obesity</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 30</b> 1961, to <b>Aug 31</b> 1961, that (I) (we) last saw the deceased alive on <b>Aug 31</b> 1961, and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>H. Dwight Bikle</b>		22b. DATE SIGNED <b>Aug 31, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. Dwight Bikle</b>		22d. ADDRESS <b>204 W. Main St., Waynesboro, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Keysville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Keysville, Carroll, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Skiles</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>		25c. ADDRESS <b>Taneytown, Maryland</b>	

CERTIFICATE OF DEATH

1918

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

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FOR STATE  
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MEDICAL CERTIFICATION

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MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09104

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY in 1b <b>40 Minutes</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Shookstown</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SHERMAN JENKINS HAMILTON</b>				4. DATE OF DEATH Month Day Year <b>August 30, 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 28, 1888</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Doctor of Dentistry</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Orleans County, N.Y.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>T. Thomas Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Jenkins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Helen O. Hamilton-Same as Item #2</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ANEURYSM of AORTA, ARTERIOSCL.</b> DUE TO (b) <b>ATHEROSCLEROSIS OF THE AORTA</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 Hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/31/1961</b> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <b>B. O. Thomas</b> EXAMINER'S NAME (Type) <b>B. O. THOMAS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 1, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. S. House</b>			

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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TO HOUSEHOLD OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9114 09105											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick - Rural - RD6</b> c. LENGTH OF STAY IN b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Near Frederick</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick - Rural - RD6</b> d. STREET ADDRESS <b>Near Frederick</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>RUSH</b>			First <b>FLOYD</b>			Middle <b>HARMON</b>			Last 4. DATE OF DEATH <b>August 30 1961</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1877</b>		9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farm Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Hezekiah Harmon</b>						14. MOTHER'S MAIDEN NAME <b>Serena Dorcas Cole</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Ada G. Harmon - Same as item #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artherosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute viral pneumonia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>many years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1957</b> to <b>Aug. 30</b> , 1961, that (I) (we) last saw the deceased alive on <b>Aug. 28</b> , 1961, and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Ernest A. Dettbarn</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>Aug. 31/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Ernest A. Dettbarn M.D.</b>						22d. ADDRESS <b>Wallersville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Sept. 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Smyth County Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison and Son, Frederick, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			



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Frederick - Rural - 10

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M. R. Robinson and Son, Frederick, Maryland

Frederick, Maryland



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9115

## CERTIFICATE OF DEATH

09106

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b> c. LENGTH OF STAY IN 1b <b>3 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Vindabona Convalescent &amp; Rest Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>West Patrick Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irwin</b> First Middle Last <b>Harry</b>		4. DATE OF DEATH Month Day Year <b>August 12 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1870</b> 9. AGE (In years last birthday) <b>91</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Frederick County</b>
13. FATHER'S NAME <b>William H. Harry</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Maude R. Hargett, R.F.D. #6, Frederick, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>794X Senility</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-29</b> , 19 <b>61</b> , to <b>8-12</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-10</b> , 19 <b>61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Rex R. Martin</b> M.D.		22b. DATE SIGNED <b>Aug 16 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rex R. Martin M.D.</b>		22d. ADDRESS <b>220 North Market St., Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>August 15, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frederick Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison &amp; Son, 106 E. Church St. Frederick, Md.</b>		25a. REG. BY REGISTRAR <b>Aug 16 61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2/15

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Production

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Production Management & Control

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Production Management & Control

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9115

MD  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09167

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Center Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Fairy Dill Henning</b> First Middle Last				4. DATE OF DEATH <b>Aug 28 1961</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 1, 1892</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John H. Long</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Wilhelm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-18-0328</b>		17. INFORMANT <b>George Henning</b> Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) <b>Chronic nephrosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>10 yrs</b> <b>10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 19, 1961</b> to <b>Aug 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 28, 1961</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Henry V. Chase</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug 28, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry V. Chase MD</b>				22d. ADDRESS <b>4 E. Church St Frederick, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 30, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Thurmont, Md. Fred. Co.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Quager</b>				ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

0115

CERTIFICATE OF DEATH

Specimen No.

Page

Number

Department of Health

Henry

John

Age 25

Residence

John H. Smith

Signature

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

John H. Smith

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John H. Smith

John H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9117

CERTIFICATE OF DEATH

09108

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle town</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>Frederick Memorial Hosp.</b>				d. STREET ADDRESS <b>—</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HAROLD Harding Hoffman</b>				4. DATE OF DEATH Month Day Year <b>August 15 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/15/1921</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ft Dietrich</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Russel Hoffmand</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Naille</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>217-03-9190</b>		17. INFORMANT Address <b>Mrs. Joyce Hoffman, Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>AS HD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>15 Aug 1961</b> to <b>15 Aug 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>15 Aug 1961</b> , and that death occurred at <b>15 Aug 1961</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J R Poirier</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>J R POIRIER</b>	
22d. ADDRESS <b>MEDICAL CENTER, Frederick Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/18/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Myersville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>gladhill</b>				ADDRESS <b>Company, Middletown, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 17 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

2117

OFFICE OF DEATH

(M)

(1)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9118											
CERTIFICATE OF DEATH											
09169											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Middletown</b>						c. LENGTH OF STAY IN 1b <b>years</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <b>Rural Middletown</b>					
3. NAME OF DECEASED (Type or print) <b>Harriet C. Holter</b>						4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>1961</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/2/1879</b>		9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Cornelius Harley</b>				14. MOTHER'S MAIDEN NAME <b>Narcissus Willard</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Willard S. Holter, Middletown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <b>Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> , 19 <b>61</b> , to <b>Aug 2</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug 2</b> , 19 <b>61</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>J Elmer Harp</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>Aug 4 61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>						22d. ADDRESS <b>Middletown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/5/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>				23d. LOCATION (City, town or county) <b>Middletown, Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>AUG 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

M

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James H. Thompson  
Chicago, Ill.

James H. Thompson, Chicago, Ill.

Chicago, Ill.

Chicago, Ill.

James H. Thompson  
Chicago, Ill.

# CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>FREDERICK</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTYTOWN</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Hallie</u> <u>MAY</u> <u>Hoy</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 8 - 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SHERMAN BIGGUS</u>	
14. MOTHER'S MAIDEN NAME <u>HATTIE RHINE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-30-5463</u>		17. INFORMANT <u>HELEN GREEN</u> <u>LIBERTYTOWN MD</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Fibrosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>2/19/60</u> 19____, to <u>8/18/61</u> 19____, that (I) (we) last saw the deceased alive on <u>8/5/61</u> 19____, and that death occurred <u>11:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Caricofe</u>		22b. DATE SIGNED <u>8/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. CARICOFE</u>		22d. ADDRESS <u>Union Bridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG 21 - 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OLDFIELDS</u>	23d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley &amp; Son</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>

CERTIFICATE OF DEATH

2112

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		Signature of Reporter	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

19111

9120

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>35 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>COURTNEY</b> Last <b>Huffer</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>THOMAS COURTNEY</b>	
14. MOTHER'S MAIDEN NAME <b>MARY ANN HANKON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MIRIAM KAMBERG FREDERICK MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis due to perforated peptic ulcer</b> 576X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>associated with acute vessel failure</b> DUE TO (c) <b>10 days.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>antecedent heart disease, atrial fibrillation.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 3, 1961</b> , to <b>August 14, 1961</b> , that I last saw the deceased alive on <b>August 13, 1961</b> , and that death occurred at <b>12<sup>30</sup> A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Nelson G. Goodman</b> M.D.		ADDRESS (Street, city or town, state) <b>810 Toll House Ave</b> DATE SIGNED <b>8/15/61</b>	
PHYSICIAN'S NAME (Type) <b>Nelson G. Goodman, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Aug 17-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET</b>	22d. LOCATION (City, town, or county) (State) <b>FREDERICK MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William C. Gaulty</b>		24a. REG'D BY REGISTRAR <b>Aug 21 61</b>	
ADDRESS <b>Frederick Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1980



NAME OF DECEASED: [illegible]  
 SEX: [illegible] AGE: [illegible]  
 DATE OF BIRTH: [illegible]  
 PLACE OF BIRTH: [illegible]  
 OCCUPATION: [illegible]  
 CAUSE OF DEATH: [illegible]  
 PLACE OF DEATH: [illegible]  
 TIME OF DEATH: [illegible]  
 SIGNATURE OF PHYSICIAN: [illegible]  
 SIGNATURE OF REGISTRAR: [illegible]  
 DATE: [illegible]





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9121

## CERTIFICATE OF DEATH

09112

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>47 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>1000 Rosemont Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE MELVIN JACOBS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>26 Sept 1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Machine Shop</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fort Detrick</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George E. Jacobs</b>				14. MOTHER'S MAIDEN NAME <b>Mabel I. Heim</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-2741</b>		17. INFORMANT <b>Mrs. Louise G. Jacobs (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Coronary Occlusion &amp; Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Sclerosis</b> (b) <b>7 yrs</b> (c) <b>5 mi</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 mi</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Heart Murmur 15 yrs</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1955</b> to <b>8/9/61</b> , that (I) (we) last saw the deceased alive on <b>7/20/61</b> and that death occurred at <b>7:40A</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. T. Brice</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10 Aug 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. T. Brice, M. D.</b>				22d. ADDRESS <b>Jefferson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 11 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9122

09113

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 412 Middle St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond William Jones First Middle Last		4. DATE OF DEATH Month 8 Day 17 Year 1961	
5. SEX Male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-1901
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer construction		11. BIRTHPLACE (County & State, or foreign country) Loudon Co Virginia	
12. CITIZEN OF WHAT COUNTRY U.S.A		13. FATHER'S NAME Edward Jones	
14. MOTHER'S MAIDEN NAME Jennie Pollard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 217-10-0255		17. INFORMANT Lillian V. Hamilton Address Frederick, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Advanced Pulmonary Tuberculosis with cavity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH App. 4-6 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 24, 1960, to Aug 17, 1961, that (I) (we) last saw the deceased alive on Aug 16, 1961, and that death occurred at 5:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Ralph L. Michels M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Ralph L. Michels		22d. ADDRESS Frederick Shopping Center, Frederick, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-19-61	
23c. NAME OF CEMETERY OR CREMATORY Lucketts, Va		23d. LOCATION (City, town or county) Lucketts (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111 ADDRESS Frederick, Md		25a. REC'D BY REGISTRAR DATE AUG 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

9183



Admission

Ref. to ...  
Ref. to ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09114

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEM. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) <u>John</u> First <u>LEWIS</u> Middle <u>KETTERMAN</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 Jan. 1910</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Ketterman 2261</u>		14. MOTHER'S MAIDEN NAME <u>MRS. CORA SWISHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>184-009-7261</u>	
17. INFORMANT <u>Mrs. Mary Tosten</u> Address <u>Broad Phoebe Rd Hagerstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL infarction</u> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>ASHD. + Hypertension</u> DUE TO (c) <u>10 year</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 Aug</u> 19 <u>61</u> to <u>8 Aug</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8 Aug</u> 19 <u>61</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Poirier</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Jean R. Poirier</u>		22d. ADDRESS <u>801 Toll House Ave, FREDERICK MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 11/61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Eden Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Greencastle Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 14 '61</u>	
ADDRESS <u>Greencastle Pa</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9124 CERTIFICATE OF DEATH 09115											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Smithsburg</b>						c. LENGTH OF STAY IN 1b <b>50 years</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route # 1</b>						d. STREET ADDRESS <b>Route # 1</b>					
3. NAME OF DECEASED (Type or print) <b>ETTA MAE KLINE</b>						4. DATE OF DEATH <b>August 22 1961</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 12, 1886</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon P. Kuhn</b>						14. MOTHER'S MAIDEN NAME <b>Amelia Ann Harrison</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Gladys Toms, Smithsburg, Md. Rt. #1</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the</b> <b>157 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>9 mos</b> DUE TO <b>Carcinoma of pancreas</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>Apr 18, 1960</b> to <b>Aug 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 22, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>G. A. Kohler</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>G. A. Kohler</b> 22b. DATE SIGNED <b>Aug 23, 1961</b> 22d. ADDRESS <b>Smithsburg, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Burial Aug. 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Lutheran</b>		23d. LOCATION (City, town or county) (State) <b>Wolfsville, Fred. Co. Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

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Rural-Smithsburg

Route # 1

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May 12, 1886

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own home

Frederick Co. Md.

U.S.A.

Simon P. Kuhn

Amelia Ann Harrison

no

none

Mrs. Gladys Toms, Smithsburg, Md. No. 41

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G. A. Kohler

Smithsburg, Md.

Postal Aug. 22, 1901 St. Martin's Lutheran Wollsville, Fred. Co. Md.

Jan. 1, 1901, Wollsville, Md.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9125

09116

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mr. Robert L. Kolb</b>				4. DATE OF DEATH <b>Aug 19 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1883</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David Kolb</b>				14. MOTHER'S MAIDEN NAME <b>Caroline V. Sawyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes.</b> (If yes, give war or dates of service) <b>VW #1</b>				16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT Address <b>Miss Alice Kolb 25 East Third St. Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>Severe Arteriosclerotic Heart Disease</b> DUE TO (c) <b>with Complete Heart Block</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Renal Diabetes</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 16 1961</b> , to <b>Aug 19 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 19 1961</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A.A. Pierre</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>A.A. Pierre M.D.</b>	
22d. ADDRESS <b>Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/21/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Frederick, Md.</b>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M.R. Etchison &amp; Son, 106 E. Church St. Frederick, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9126

## CERTIFICATE OF DEATH

09117

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		
c. LENGTH OF STAY IN 1b <b>Life</b>			d. STREET ADDRESS <b>13 East Second Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Frederick Memorial Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>MARY CHRISTINE LAMPE</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>August 20, 1961</b>		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>1 July 1872</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired-Manager</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Department Store</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick, Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>			<b>13. FATHER'S NAME</b> <b>Christian L. C. Lampe</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E. Babel</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		
<b>16. SOCIAL SECURITY NO.</b> <b>None</b>			<b>17. INFORMANT</b> Address <b>Miss Mary E. Rhoads (Same as item #2)</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio-sclerotic Heart Disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>unknown</b>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>8-19</b> <b>1961</b> , to <b>8-20</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>8-20</b> <b>1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>Thomas E. Stone, M. D.</b>			<b>22b. DATE SIGNED</b> <b>22 Aug 1961</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type)			<b>22d. ADDRESS</b>		
<b>Thomas E. Stone, M. D.</b>			<b>4 W. 3rd St., Frederick, Md.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8-23-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mount Olivet Cemetery</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Frederick, Maryland</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			<b>25a. REC'D BY REGISTRAR</b> <b>AUG 23 '61</b>		
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Stone</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

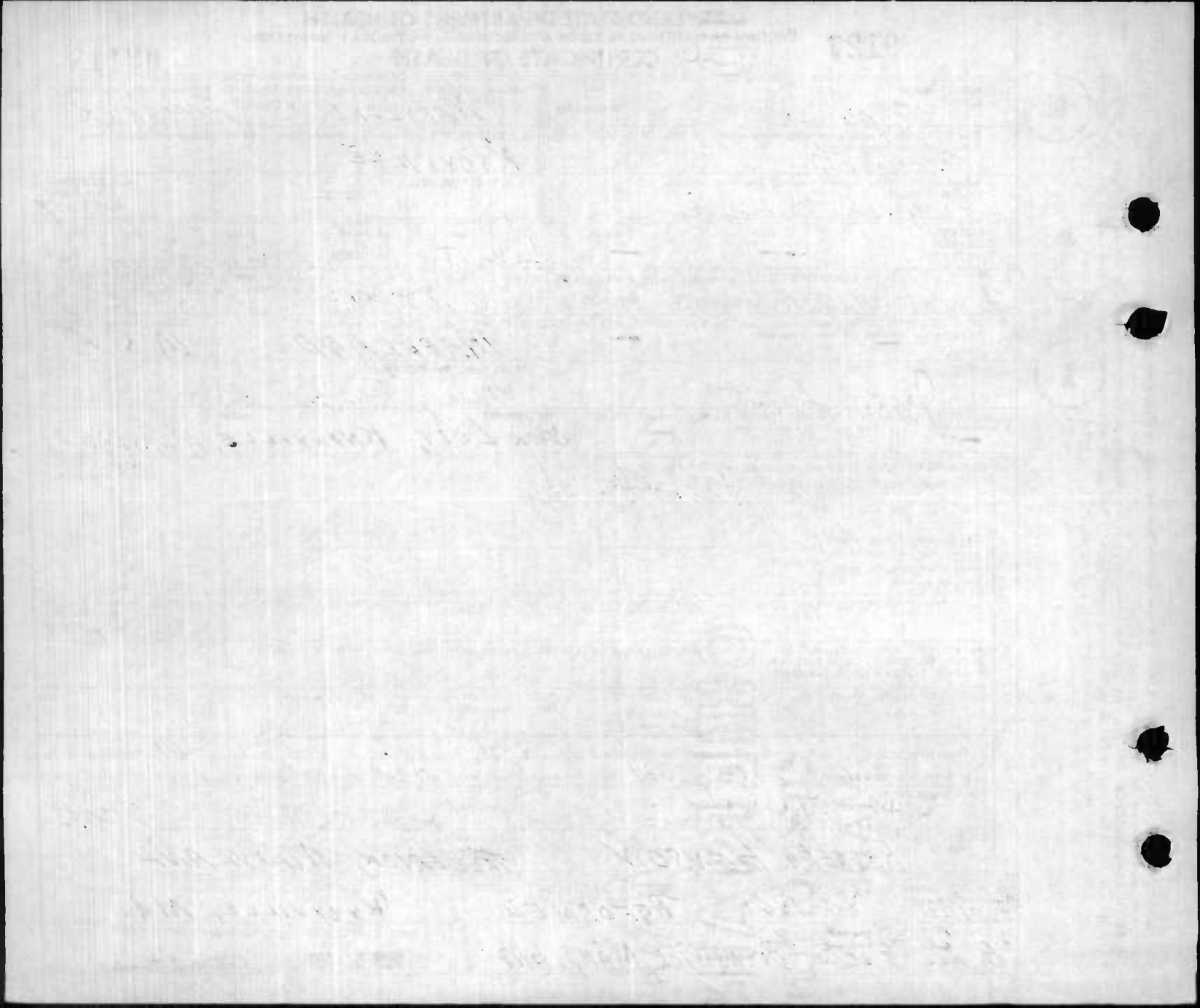
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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
09118										
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KNOXVILLE X</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>					d. STREET ADDRESS <u>— 1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First <u>—</u> Middle <u>—</u> Last <u>Lust</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1961</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 29, 1961</u>		9. AGE (In years, last birthday) yrs. <u>—</u> IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS. Hours <u>2</u> Min. <u>40</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jack Lust</u>					14. MOTHER'S MAIDEN NAME <u>Mary Louise Barr</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>JACK LUST, KNOXVILLE, MARYLAND</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>61</u> , to <u>8/29</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/29</u> , 19 <u>61</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Adm. R. C. Nelson</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/29/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>KENNETH HENSON</u>					22d. ADDRESS <u>FREDERICK, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>8-1-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REFORMED</u>		23d. LOCATION (City, town, or county) (State) <u>KNOXVILLE, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>B. Lee Fante, BRUNSWICK, MARYLAND</u>					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>SEP 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

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TO HOSPITAL OR AT HOME. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
9128														
09119														
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> c. LENGTH OF STAY IN 1b <b>20 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>23 Taney Apts.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Jesse Thomas McDonough</b>					4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1898</b>		9. AGE (In years last birthday) <b>63</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employed Goodwill Industries</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Co., Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>							
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>														
13. FATHER'S NAME <b>Vernon McDonough</b>					14. MOTHER'S MAIDEN NAME <b>Rosie Histler</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>216-22-7816</b>					17. INFORMANT <b>Mrs. Maude S. McDonough 23 Taney Apts. Fred. Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephro sclerosis</b> <b>446 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1961</b> , to <b>Aug 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 3, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Dr. R. L. Michels</b>					M.D. <b>Frederick Shopping Center, Frederick, Md.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 5, '61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. R. L. Michels</b>					22d. ADDRESS <b>Frederick Shopping Center, Frederick, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>8-7-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Frederick, Maryland</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dailey &amp; Son</b>					ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>					

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

09120

M

9129

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u> ✓	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Frederick (Rural)</u>		<u>3 weeks</u>		<u>Sandy Hook</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monocacy Hall Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Main Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>CARRIE</u> (Middle) <u>AMELIA</u> (Last) <u>MIRLEY</u>				<u>Aug. 18,</u> 19 <u>61</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 30, 1887</u>	<u>74</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Sandy Hook, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas Dunn</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Lee Phelps</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Claude Kimes</u> <u>Box 220, Knoxville, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE</b> (A) <u>Bronchopneumonia</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u>			
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>Arteriosclerosis</u>				<u>5 yrs.</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO (C) <u>Parkinson's Disease</u>				<u>5 yrs.</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Aug. 26,</u> 19 <u>59</u> , to <u>Aug. 18,</u> 19 <u>61</u> , that I last saw the deceased alive on <u>Aug. 18,</u> 19 <u>61</u> , and that death occurred at <u>2:15A</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Gum Spring Hollow</u> <u>M.D. Brunswick, Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>8/21/61</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Sandy Hook, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>AUG 22 '61</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> <b>ADDRESS</b> <u>Harpers Ferry West Va.</u>			

# CERTIFICATE OF DEATH

1938

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Day, Month, Year

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF BIRTH

12. PLACE OF DEATH

13. DATE OF BIRTH

14. TIME OF BIRTH

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RECEIVED

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING, IS



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it may be retained for your files. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9130 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09121									
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keymar RD 2</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Keymar RD 2</u>				
c. LENGTH OF STAY IN 1b <u>3 weeks</u>					d. STREET ADDRESS <u>1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Catherine Loretta Nelson</u>					4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1961</u>				
5. SEX <u>F</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>August 17, 1900</u>				
9. AGE (in years last birthday) <u>60</u> yrs.					IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				
11. BIRTHPLACE (State or foreign country) <u>Hanover, Pa</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Harry Hagerman</u>					14. MOTHER'S MAIDEN NAME <u>Sarah McMaster</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Dolores Conner</u>					Address <u>Keymar RD 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of neck Cervical vertebrae</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Osteoporosis of vertebrae</u> DUE TO (c) <u>900.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>5 yrs +</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps at home</u>				
20c. TIME OF INJURY Month, Day, Year <u>145</u> Hour <u>8/9</u> a.m. <u>1961</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>					20f. (City or town) (County) (State) <u>Keymar RD 2 Frederick MD</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>B. O. Thomas</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) <u>August 9, 1961</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>AUG-10-1961</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE</u>					22d. LOCATION (City, town, or country) (State) <u>BALTIMORE MD</u>				
23. FUNERAL DIRECTOR <u>W. Hartzler &amp; Sons, Union Bridge</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 14 '61</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>				



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9131

## CERTIFICATE OF DEATH

Reg. Dist. No. 09122

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>FREDERICK</u>		STATE <u>MARYLAND</u>		CITY <u>FREDERICK</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY <u>FREDERICK</u>	
TOWN <u>WOODSBORO</u>		<u>YEARS</u>		TOWN <u>WOODSBORO</u>		COUNTY <u>FREDERICK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>AMY REBECCA POWELL</u>				<u>AUGUST 23, 1961</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>JULY 8 - 1874</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>HOUSEWIFE</u>		<u>AT HOME</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN WILLIAM CRAMER</u>				<u>REBECCA SPAHR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NO</u>		<u>L.C. POWELL WOODSBORO MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
443X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Cerebral softening</u>						<u>48 hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerotic cardiovascular disease</u>						<u>7 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Important foreign essential</u>						<u>10 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1950</u> , to <u>23 Aug 1961</u> , that I last saw the deceased alive on <u>23 Aug 1961</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James F. Stone Jr.</u>		M.D. <u>Walherville, Md.</u>		DATE SIGNED <u>8/24/61</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8/26/61</u>		<u>MT HOPE CEM.</u>		<u>WOODSBORO MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>462961</u>		<u>Arthur S. Hays</u>		<u>Powell &amp; Hartzler</u>		<u>WOODSBORO MD</u>	
DATE							



TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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9132

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09123

Item 2 - from birth cert. 8/29/61 ink

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i> c. LENGTH OF STAY IN 1b <i>Frederick</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodbine</i> d. STREET ADDRESS <i>Rt. #1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Randolph</i> Middle <i>Rash</i> Last <i>Rash</i> 4. DATE OF DEATH Month <i>August</i> Day <i>25</i> Year <i>1961</i>		5. SEX <i>None Demonstrable Boy</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>8-7-61</i> 9. AGE (In years last birthday) <i>18</i> yrs. IF UNDER 1 YEAR Months <i>18</i> Days <i>18</i> Hours <i>18</i> Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>CLAUDE Robert Rash</i>		14. MOTHER'S MAIDEN NAME <i>Carol EILEE DORSEY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intestinal obstruction, peritonitis</i> 756.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>Imperforate Anus, Omphalocele</i> (c) <i>several days congenital Deformities</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Absence of right kidney, Malrotation of intestines,</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 14, 1961</i> to <i>Aug 25, 1961</i> , that (I) (we) last saw the deceased alive on <i>8/24, 1961</i> , and that death occurred at <i>4 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>W.B. Culwell</i>		22b. ADDRESS <i>Mt Airy, Md.</i>	
22c. PHYSICIAN'S NAME (Type) <i>DR. W.B. Culwell</i>		22d. ADDRESS <i>Mt Airy, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>8/26/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Frederick Memorial Hospital</i>		23d. LOCATION (City, town, or county) (State) <i>Frederick, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. David Youngdahl</i>		25a. REG. DAY REGISTRAR <i>Aug 29 61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>		25c. REGISTRAR'S SIGNATURE	

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RECEIVED  
JAN 11 1961  
U.S. DEPT. OF HEALTH  
BUREAU OF PUBLIC HEALTH  
OFFICE OF VETERANS AFFAIRS



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9133

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9124

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
c. LENGTH OF STAY IN lb 30 yr.		d. STREET ADDRESS Lombard St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dallas Currens Reid	4. DATE OF DEATH August 8 1961		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Postal Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton D. Reid		14. MOTHER'S MAIDEN NAME Margaret E. Currens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. no lost	
17. INFORMANT Katherine G. Reid		Address Thurmont, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-61	
22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Md. Fred. Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond S. Cragg		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

DATE SIGNED  
8-8-61

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
John S. Jones		45		Male		White		Roman Catholic	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Baltimore, Md.		Jan 15, 1950		Home		Myocardial Infarction		Natural	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MILITARY SERVICE	
Salesman		High School		Married		No		None	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
Hypertension		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		OFFICE	
J. D. Smith		Jan 15, 1950		10:00 AM		Home		Baltimore, Md.	
OFFICIAL SEAL		FEE		TAXES		BURIAL		REMARKS	
[Seal]		\$10.00		\$5.00		Buried in St. Mary's Cemetery		None	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9134

08125

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>BARK HILL 06X-1</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>H</b> Last <b>SHAFFER</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 7-1884</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN SHAFFER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH (UNKNOWN)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>716-12-3711</b>	
17. INFORMANT <b>BERTHA SHAFFER</b>		Address <b>RURAL UNION BRIDGE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR ACCIDENT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>15 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>7/30</b> , 19 <b>61</b> , to <b>8/5</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/4</b> , 19 <b>61</b> , and that death occurred at <b>2:30</b> PM, from the causes and on the date stated above.	
22a. SIGNATURE <b>Richard C. Reynolds</b> M.D.		22b. DATE SIGNED <b>8/5/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD C. REYNOLDS</b>		22d. ADDRESS <b>FREDERICK MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG 7-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT ZION</b>		23d. LOCATION (City, town, or county) (State) <b>FREELANDS MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W Hartzler &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>AUG 8 '61</b>	
ADDRESS <b>Union Bridge</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

(M)

1134

STATE OF OHIO

County of \_\_\_\_\_

Shirley A. \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9135

## CERTIFICATE OF DEATH

09126

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Frederick</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Myersville</b> c. LENGTH OF STAY in lb <b>19 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Myersville</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MELISSA</b> Middle <b>LUCRETIA</b> Last <b>SHANK</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>15</b> Year <b>1961</b>	
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>February 24, 1881</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own home</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Frederick Co. Md.</b>
<b>13. FATHER'S NAME</b> <b>Tilghman F. Grossnickle</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Salome A. Grossnickle</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>	
<b>17. INFORMANT</b> <b>Russell R. Shank, Myersville, Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>	
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>8/15 (9:30 AM)</b>
<b>21. I certify that (II) (this hospital) (the deceased) died on</b> <b>8/15 (9:30 AM) 1961</b> , <b>to</b> <b>8/15</b> , <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>8/15 (9:30 AM) 1961</b> , <b>and that death occurred at</b> <b>1:30 PM</b> , <b>from the causes and on the date stated above.</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>22a. SIGNATURE</b> <b>Kenneth C. Hanson</b>		<b>22b. DATE SIGNED</b> <b>8/16/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Kenneth C. Hanson</b>		<b>22d. ADDRESS</b> <b>Middletown, Md</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Aug. 18, 1961</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Grossnickle's</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Paul F. Bittle</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Thos S. Hwang</b>	
<b>25a. REC'D BY REGISTRAR</b> <b>AUG 21 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Thos S. Hwang</b>	

(M)

Frederick

Myersville

Frederick

Myersville

19 years

Myersville

MELISSA

LAUREN

SHANN

August 15

61

female white

X

February 24, 1981 80

housewife

own home

Frederick Co. Md.

U.S.A.

Tilghman F. Grossnickle

Salome A. Grossnickle

no

none

Russell R. Sharr, Myersville, Md.

Born Aug. 19, 1961 Grossnickle's

Mr. Myersville, Fred. Co. Md.

Paul F. Biddle, Myersville, Md.



**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9136

09127

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Alleghany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>19 Prospect Square</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>First Jane Hazelton Middle Smith Last Smith</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OF RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 28, 1878</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George D. De Shields</b>		14. MOTHER'S MAIDEN NAME <b>Jane Hazelton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William A. Gunter, 7 Washington St. Cumberland, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 6, 1961</b> to <b>Aug 17, 1961</b> , that (I) (we) lost saw the deceased alive on <b>Aug 17, 1961</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. A. Pearre</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M.D.</b>				22d. ADDRESS <b>Frederick, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				25a. REG. BY REGISTRAR <b>Aug 21 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
George Funeral Home, 202 Greene St. Cumberland, Md.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09128

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN 1b <b>years</b>				d. STREET ADDRESS <b>27 East Patrick Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Russell</b> Middle <b>William</b> Last <b>Smith</b>		4. DATE OF DEATH		Month <b>August</b> Day <b>24</b> , Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-12-1906</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Store Employee</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin E. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mary Krantz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5901</b>		17. INFORMANT Address <b>Mrs. Mildred S. Smith 27 E. Patrick St. Fred.Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) 420.1							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>B. Thomas</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 24, 1961</b>			
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR <b>Robert E. Bailey &amp; Son</b> ADDRESS <b>Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 29 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

MEDICAL CERTIFICATION

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Frederick J. Breyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9138 CERTIFICATE OF DEATH 09129									
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>					c. LENGTH OF STAY IN 1b <b>Years</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>232 East Sixth Street</b>					d. STREET ADDRESS <b>232 East Sixth Street</b>				
3. NAME OF DECEASED (Type or print) <b>FREDERICK GILMORE TYERYAR</b>					4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9 Feb 1892</b>		9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Custom Work</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pearl, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rudolph Tyeryar</b>					14. MOTHER'S MAIDEN NAME <b>Alice Phelps</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-05-2815</b>		17. INFORMANT Address <b>Mrs. Alice Staley, RD#3, Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO <b>Cholecystitis, Acute</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>1 week</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick, Md.</b>		20g. (County) <b>Frederick</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1957</b> to <b>Aug 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 31, 1961</b> , and that death occurred <b>21:40</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Bernard O. Thomas, Jr., M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2 Sept 1961</b>		
22c. PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas, Jr., M. D.</b>					22d. ADDRESS <b>228 N. Market St., Frederick, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frederick, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		





9139

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

Item 7 Film 6295 9/19/61 iwk

09130

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>		c. LENGTH OF STAY IN 1b <b>709 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>—</b> Last <b>Weeks</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-05</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cab business</b>	
11. BIRTHPLACE (State or foreign country) <b>Hyattsville US</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John W. Weeks</b>		14. MOTHER'S MAIDEN NAME <b>Ida Simmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-05-5912</b>	
17. INFORMANT <b>Records</b>		Address <b>Victor Cullen State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> 002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-2-59</b> 19 to <b>8-10-61</b> 19, that (I) (we) last saw the deceased alive on <b>8-10-61</b> 19, and that death occurred at <b>12.35pm</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Michael G. Zavis</b>		22b. DATE SIGNED <b>8-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael G. Zavis</b>		22d. ADDRESS <b>Victor Cullen State Hospital Cullen, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 13, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Monterey Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Monterey Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Class Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 '61</b>	
ADDRESS <b>Hyattsville Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

Victor G. Smith, Jr.

1940

1940-1941

1941-1942

1942-1943

1943-1944

1944-1945

1945-1946

1946-1947

1947-1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9140											
09131											
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b> c. LENGTH OF STAY in 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>New Addition</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Knoxville</b> d. STREET ADDRESS <b>New Addition</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William Robert Winstead</b>						4. DATE OF DEATH Month <b>8</b> Day <b>3</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-14-1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired B.&amp;O.R.R. Steam Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Winstead</b>						14. MOTHER'S MAIDEN NAME <b>Olivia King</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert M. Winstead, Martinsburg, W. Va.</b>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>450.0</b> DUE TO <b>Anterior myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (a) (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/16</b> to <b>8/3</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/3</b> , 19 <b>61</b> , and that death occurred <b>9:00</b> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <b>J.G.F. Smith</b>						22b. DATE <b>8/16/61</b>			22c. ADDRESS <b>Brunswick, Maryland</b>		
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b. DATE THEREOF <b>8-5-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine View</b>		23d. LOCATION (City, town or county) (State) <b>Rockey Mount, North Carolina</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Felt</b>						ADDRESS <b>Brunswick, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>	

VR A15 (4)  
15M 9/60

(M)

(1)

*Robert - very good*

*Handwritten signature*

*Handwritten notes and signatures at bottom left*

TO HO...AL OR A...ING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>																																															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>												c. LENGTH OF STAY IN lb <b>Since 6/61</b>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>																																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Monocacy Hall Nursing Home</b>																								d. STREET ADDRESS <b>Jefferson</b>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <b>LETTIE IRENE WISE</b>												4. DATE OF DEATH <b>August 29, 1961</b>																																															
5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>31 Dec 1881</b>				9. AGE (In years last birthday) <b>79</b> yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.																																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>												10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>												11. BIRTHPLACE (County & State, or foreign country) <b>Jefferson, Md.</b>												12. CITIZEN OF WHAT COUNTRY? <b>USA</b>																							
13. FATHER'S NAME <b>Henry C. Wise</b>												14. MOTHER'S MAIDEN NAME <b>Alverta Sparrow</b>																																															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>												16. SOCIAL SECURITY NO. <b>None</b>												17. INFORMANT <b>Miss Nellie L. Mehrling, Frederick, Md.</b>												Address <b>11 E. Patrick St.,</b>																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial decompensation</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Colon with metastasis 1 yr</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																															
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>Jefferson, Maryland</b>				(County) <b>Jefferson</b>				(State) <b>Md.</b>																																							
21. I certify that (I) (this hospital) attended the deceased from <b>May 1961</b> to <b>8/29, 1961</b> ; that (I) (we) last saw the deceased alive on <b>8/16, 1961</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.																																																											
22a. SIGNATURE <b>A. T. Brice</b> M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Jefferson, Maryland</b>												22b. DATE SIGNED <b>31 Aug 1961</b>																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>												23b. DATE THEREOF <b>9-1-61</b>												23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>												23d. LOCATION (City, town or county) <b>Jefferson, Maryland</b>												(State) <b>Md.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>												ADDRESS <b>Frederick, Maryland</b>												25a. REC'D BY REGISTRAR DATE <b>SEP 5 '61</b>												25b. REGISTRAR'S SIGNATURE <b>W. L. H. H. H.</b>																							

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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b6 , b7C : 100-108

Subject: corollas

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